AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155338	A. BUII	LDING		03/14/2011	
		199996	B. WIN			03/14/20	11
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MANODO	ADE HEALTH SED	RVICES - PRESTWICK			COUNTY ROAD 525 EAST IN46123		
				·	+		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· · · · · · · · · · · · · · · · · · ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION DATE
IAG	REGULATORT OR	ESC IDENTIF TING INFORMATION)	+	IAG	·		DAIL
F0000	This visit was for	r the Investigation of	F00	00	The facility is submitting this Pla		
	Complaint IN000	087451. This visit			Correction because of requirement		
	resulted in a parti	ially extended survey -			by Federal Regulation.		
	Immediate Jeopa	rdy.			The submission of this plan does	not	
					constitute agreement with or an		
	Complaint IN000	087451 - Substantiated.			admission on the part of Manor C		
	Federal/State def	iciencies related to the			Health Services – Prestwick as to	the	
	allegations are ci	ted at F272, F279 and			accuracy of the statements or conclusions contained in the		
	F323.				statement of deficiencies.		
					statement of deficiencies.		
	Survey date: March 11, 2011						
	Extended survey	dates:					
	March 12, 13 an						
		,					
	Facility number:	000231					
	Provider number						
	AIM number:	100267900					
	Survey team:						
	Vanda Phelps, R	N					
	Census bed type:						
	SNF:	38					
	SNF/NF:	74					
	Total:	112					
		-					
	Census payor typ	oe:					
	Medicare:	29					
	Medicaid:	66					
	Other	17					
	Total:	112					
	101.11.	114					
LABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIC	GNATURE		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0TZ011

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		155338	A. BUILDING B. WING		- 03/14/2		
NAME OF F	PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP COL			
MANOR	CARE HEALTH SER	RVICES - PRESTWICK		S COUNTY ROAD 525 EAS DN, IN46123	ı		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SHO	ECTION	(X5)	
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	CROSS-REFERENCED TO THE API	PROPRIATE	COMPLETION DATE	
	Sample:	3					
	Supplemental sar	mple: 1					
	These deficiencie	es also reflect state					
		accordance with 410 IAC					
	16.2.						
	Quality review 3/17	/11 by Suzanne Williams, RN					

VICES VICES PRINTED: 04/07/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 155338 03/14/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 445 S COUNTY ROAD 525 EAST MANORCARE HEALTH SERVICES - PRESTWICK AVON. IN46123 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE F0272 Based on observation, record review and F0272 The facility is submitting this Plan of 03/28/2011 Correction because of requirement interviews, the facility failed to conduct SS=D by Federal Regulation. comprehensive assessments following a witnessed elopement during which the The submission of this plan does not resident exhibited the ability to plan and constitute agreement with or an admission on the part of Manor Care execute his plan. This impacted 1 of 3 Health Services – Prestwick as to the residents reviewed for exit seeking accuracy of the statements or behavior in the sample of 3. (Resident conclusions contained in the X) statement of deficiencies. What corrective action will be Findings include: accomplished for those residents found to have been affected by the During the orientation tour on 3/11/2011 deficient practice? at 9:45 a.m., LPN (Licensed Practical Resident X's care plan was updated Nurse) #1 identified Resident X as on 03/08/11 in order to address the resident's ability to plan and execute having eloped twice recently. He was an elopement attempt. Resident X observed at the time ambulating rapidly was discharged from the facility on through the facility with a stern facial 03/16/11. expression. He was observed in the 600 hall, the 800 hall and the front lobby. How will other residents having the potential to be affected by the same deficient practice be The clinical record of Resident X was identified and what corrective reviewed on 3/11/2011 at 3 p.m. It actions will be taken? indicated he was admitted to this facility Patients in the facility with exit on 12/2/2009. His diagnoses included, seeking and unsafe wandering but were not limited to, Parkinson's behavior have been identified. New disease, dementia, depression and admissions with exit seeking and anxiety. It indicated Resident X had unsafe wandering behavior have the exhibited exit seeking behavior and potential to be affected and will be identified in our IDT meetings. wandering consistently since admission and wore a WanderGuard device which What measures will be put in place electronically locks the doors when the or what systemic changes will be device comes close to the exit. made to ensure that deficient

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0TZ011

000231

Facility ID:

If continuation sheet

Page 3 of 15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/14/2011	
	PROVIDER OR SUPPLIEF	RVICES - PRESTWICK		445 S C	ADDRESS, CITY, STATE, ZIP CODE COUNTY ROAD 525 EAST IN46123		
(X4) ID PREFIX TAG	The nursing note had eloped on Sap.m., by sitting rather when a visitor whim while the door outside. Althout WanderGuard, he because the door visitor had immediate happened and state with Resident X one-half block fit trying to elude the His last MDS (Nassessment was a indicated his should be wandering behave period. It was not 2/19/2011 eloped Resident X had be evaluated by a previdence this was 2/19/2011 eloped Nursing notes of became aware R noon. After a sagrounds, 9-1-1 was not some aware R noon. After a sagrounds, 9-1-1 was not some aware R noon. After a sagrounds, 9-1-1 was not some aware R noon. After a sagrounds, 9-1-1 was not some aware R noon. After a sagrounds, 9-1-1 was not some aware R noon. After a sagrounds, 9-1-1 was not some aware R noon. After a sagrounds, 9-1-1 was not some aware R noon.	estatement of deficiencies and was able to exit and was already open. The adiately reported what had aff were able to catch up the equivalent of about from the door. He fell the staff. Minimum Data Set) dated 2/7/2011. It out term memory was son exhibiting wior during the assessment out updated after the ment. E3/7/2011 indicated staff esident X was missing at earch of the building and was called. The		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) practices do not occur? The interdisciplinary team and u managers received training on documentation of completing assessments, prevention and management of exit seeking and unsafe wandering behaviors. Unit Managers/Designee will au documentation 5X weekly for 4 weeks and forward results to AD for further actions if needed. How will the corrective actions be monitored to ensure the deficient practice will nor recur Audits will continue by Unit Manager/Designee weekly there. ADNS will monitor documentation for assessments weekly X 4 weethen as determined by the QA & committee for frequency to ensure accuracy has been achieved. Findings will be forwarded to QA A Committee for further review recommendations.	nit dit DNS (s) r? after. ion ks A rre	(X5) COMPLETION DATE
	Auministrator in	dicated during an					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S COMPLI	ETED	
		155338	B. WIN			03/14/20)11
NAME OF P	ROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE	•	
MANORO	NOE HEALTH SEE	RVICES - PRESTWICK		1	COUNTY ROAD 525 EAST IN46123		
			-	<u>.</u>	11140123		(375)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	interview on 3/11	1/2011 at 10:50 a.m., the				ĺ	
	police dispatcher	told him the police had					
		lying in a ditch along					
	highway 36 and an ambulance had been called. Review of the emergency room documentation on 3/11/2011 at 1:30 p.m. indicated he had arrived there on 3/7/2011 at 14:40 (2:40 p.m.), more than 2.5 hours						
		m.), more than 2.5 hours discovered he was					
	•						
	missing. Although the facility had investigated the second elopement, they						
	were unable to determine how Resident X had been able to leave the facility.						
		•					
	Interview with th	e Administrator and the					
	Director of Nursi	ing on 3/11/2011 at 4:45					
	p.m. indicated it						
	•	ssess Resident X until					
	after the 3/7/11 e	lopement.					
	This Call 14	1.44					
	This federal tag in IN00087451.	relates to complaint					
	1110000/431.						
	3.1-31(c)(7)						
	3.1-31(c)(12)						
	3.1-31(d)(1)						
	,,,,						

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE SI	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLE	ETED
		155338	B. WING			03/14/20)11
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				COUNTY ROAD 525 EAST		
MANOR	CARE HEALTH SER	RVICES - PRESTWICK			IN46123		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0279	Based on observa	ation, record review and	F02	79	The facility is submitting this P	lan	03/28/2011
SS=D	interviews, the fa	cility failed to update the			of Correction because of		
	care plan in a tim	nely manner to reflect the			requirement by Federal Regulation. The submission of	,	
	resident's demon	strated ability to plan and			this plan does not constitute	' I	
		ment attempt. This			agreement with or an admission	on	
	-	residents reviewed for			on the part of Manor Care Hea		
	•	evice in the sample of 3.			Services – Prestwick as to the		
	_	tvior in the sample of 3.			accuracy of the statements or		
	(Resident X)				conclusions contained in the		
					statement of deficiencies What corrective action will be	^{at}	
	Findings include:				accomplished for those		
					residents found to have been	,	
	LPN (Licensed P	Practical Nurse) #1			affected by the deficient	•	
	indicated, during	g the orientation tour			practice? Resident X's care p	olan	
	3/11/2011 at 9:4	5 a.m., Resident X had			was updated on 3-8-11 in orde		
	wandering and ex	xit seeking behaviors,			address the resident's		
	_	eloped twice. He was			demonstrated ability to plan ar		
	_	me ambulating rapidly			execute an elopement attempt		
		0 1 5			Resident X was discharged from the facility on 03/16/11. How was discharged from the facility on 03/16/11.		
		icility with a stern facial			other residents having the	w'''	
	-	vas observed in the 600			potential to be affected by th	e	
	hall, the 800 hall	l and the front lobby.			same deficient practice be	Ĭ	
					identified and what corrective	е	
		rd of Resident X was			actions will be taken?		
	reviewed on 3/11	/2011 at 3 p.m. It			Residents that have the poten	tial	
	indicated he was	admitted to this facility			to be affected have had their		
	on 12/2/2009. H	is diagnoses included,			plans of care reviewed and		
		ted to, Parkinson's			updated as appropriate. New residents will be identified upo	,	
		a, depression and			admission for their exit seeking		
		ated Resident X had			behavior and unsafe wandering		
	1	eking behavior and			behaviors with care plans put	- 1	
		-			place as required. What		
	_	stently since admission			measures will be put in place		
		lerGuard device which			or what systemic changes w	iII	
	<u>-</u>	eks exit doors when the			be made to ensure that		
	device comes clo	ese to that exit.			deficient practices do not occur? The interdisciplinary		
					occur interdisciplinary		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0TZ011

Facility ID:

000231

If continuation sheet

Page 6 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC		COMPL	ETED
		155338	B. WIN			03/14/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	8					
		N. (1050 DD507141014		1	COUNTY ROAD 525 EAST		
MANOR	JARE HEALTH SEF	RVICES - PRESTWICK		AVON,	IN46123		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					team and nurse managers have		
	The nursing note	es indicated Resident X			been re-educated on the prope		
	had eloped on Saturday, 2/19/2011 at 2				procedures for prevention and		
	•	near the front door and,			management of exit seeking	_	
					behavior and unsafe wandering behaviors. Social Service and		
		as leaving, pushed past			License Nursing staff have	u	
		or was still open and got			re-educated on exit seeking a	_{nd}	
	outside. Althou	gh he was wearing a			unsafe wandering behavior an		
	WanderGuard, h	ne was able to exit			care plans and assessment.		
	because the door	was already open. The			Residents identified as having	, l	
		ediately reported what had			exit seeking behaviors and		
		aff were able to catch up			unsafe wandering behaviors h		
		_			had their medical record revie		
		the equivalent of about			to ensure the appropriate tracl		
		om the door. He fell			tools and care plans are in pla		
	trying to elude th	ne staff.			with the appropriate intervention addressed. How will the	JIIS	
					corrective actions(s) be		
	Clinical record re	eview included the care			monitored to ensure the		
	nlan There was	s an entry addressing			deficient practice will nor		
	-	nitiated on 6/21/2010, but			recur? Resident's exit seeking	,	
	•	ed after the 2/19/2011			and unsafe wandering behavior		
	_				will be monitored 5X a week for		
	_	interventions remained			weeks by Social Service or		
	as:				designee to verify all residents	;	
	"check wanderg	uard placement and			with exit seeking or unsafe		
	function q (every	y) shift " (initiated			wandering behaviors have been	en	
	6/21/2010)				appropriately addressed. Residents with any new areas	of	
	ensure that (wif	e's name) signs resident			concern will be addressed and		
		aff aware when leaving			care plans will be implemented		
		· ·			that time. The		
		into the building"			Administrator/Designee will au	ıdit	
	(initiated 9/2/201	· ·			social service documentation		
	_	to an appropriate area,			through 2 chart audits per wee	ek	
	activities, meals	and reassure" (initiated			for 4 weeks and then as		
	9/2/2010)				determined by the QA & A		
	"encourage socia	alization with others and			committee, of current resident	s	
	-	onal programming,			with exit seeking behaviors to ensure the care plans are		
	Fig. 130 Tooloutie	F 6 6 6 6 6 6 6			Choule the cale plans are		
	i e e e e e e e e e e e e e e e e e e e		1		i e		i l

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155338	A. BUI B. WIN			03/14/20	011
			р. wп		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			445 S C	COUNTY ROAD 525 EAST		
		RVICES - PRESTWICK			IN46123		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	COMPLETION DATE
1710		ead magazine" (initiated		1110	appropriate. The results of th	e	DITTE
	9/2/2010)	ad magazine (initiated			audits will be submitted to QA		
	Nursing notes on Monday, 3/7/2011,				Committee for further review and		
					recommendations.		
		staff became aware					
	1	nissing about 12 noon.					
		seen at approximately					
		ystematic search of the					
	l *	unds failed to locate					
	Resident X so 9-	1-1 was called. The					
	resident was four	nd by police 1.5 miles					
	from the facility	lying in a ditch along					
	State Road 36.	Review of Emergency					
	Room documenta	ation on 3/11/2011 at					
	_	ed Resident X arrived					
	there at 2:40 p.m	., i.e. 2.5 hours after					
	facility staff notice	ced he was missing.					
	Two new interve	entions were added to the					
	care plan entry a	ddressing elopement risk					
	on 3/8/11:						
		Center Watch Book and					
		" (initiated 3/8/2011)					
		elings and/or frustration					
	_	th calling wife, kids, or					
		with calming down"					
	(initiated 3/8/201	1)					
	During interview	3/11/2011 at 4:45 p.m.,					
	neither the Admi	nistrator nor the Director					
	of Nursing offere	ed an explanation for					
	failure to update	the care plan after the					
	2/19/2011 eloper	ment.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155338	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 03/14/2011	
	PROVIDER OR SUPPLIER	RVICES - PRESTWICK	445 S C	ADDRESS, CITY, STATE, ZIP CO COUNTY ROAD 525 EAS IN46123			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	This federal tag in IN00087451. 3.1-35(b)(1)	relates to complaint					

PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY DAG **PROVIDERS**PLAN OF CORRECTION (EACH CORRECTION) COMP **COMP **COM	X5) LETION ATE 8/2011
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 445 S COUNTY ROAD 525 EAST AVON, IN46123 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMP	LETION ATE
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 445 S COUNTY ROAD 525 EAST AVON, IN46123 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY) TAG DEPICIENCY) DATE: OUT OF THE PROVIDER'S PLAN OF CORRECTION COMPANY OF THE PROPRIATE DEPICIENCY TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEPICIENCY	LETION ATE
MANORCARE HEALTH SERVICES - PRESTWICK (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 445 S COUNTY ROAD 525 EAST AVON, IN46123 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE: OUTPITED A 445 S COUNTY ROAD 525 EAST AVON, IN46123	LETION ATE
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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DA	ATE
THE REGULTION ON ESCHEDING THOUGHTON)	
	8/2011
of Correction because of	
SS=J interview, the ffacility ffailed to monitor and requirement by Federal	
provide supervision to ensure the saffety off a Regulation. The submission of	
resident with a history off exiting the ffacility this plan does not constitute	
resulting in Immediate Jeopardy because off agreement with or an admission	1
the risk off serious harm,injury, or death to 1 on the part of Manor Care Health	· ·
off 3residents reviewed ffor exit seeking Services – Prestwick as to the	
behaviors in the sample off3. (Resident X) accuracy of the statements or	
conclusions contained in the	
The Immediate Jeopardy began on statement of deficiencies. What corrective action will be	
2/19/2011 when a resident was returned to accomplished for those	
the ffacility affer an elopement and without residents found to have been	
the implementation off a plan to prevent affected by the deficient	
ffurther elopements The Administrator and practice? Resident X was	
I I returned to the facility and	
Director off Nursing were notified off the immediately placed on 1: 1	
immediate jeopardy at 4:45 p.m. on supervision. Resident X was	
3/11/2011. The immediate jeopardy was discharged from the facility on	
removed on 3/07/2011 when, based on 03/16/11 How will other	
record review and interview, the resident reside	
was placed on contnuous 1:1 monitoring, to be affected by the same deficient practice be identified	
but the noncompliance remained at the and what corrective actions	
lower scope and severity level off isolated will be taken? Residents will be	
with no actual harm with potential ffor more identified on admission for the	
than minimal harm that is not immediate risk of exit seeking. On a monthly	
jeopardy because the ffacility ffailed to ffully basis resident who are currently	
implement a plan to prevent the resident identified as exit seekers or who	
ffrom exiting the ffacility in the ffuture have had a significant change will have had a significant change will have had a significant change will	
be reviewed for ongoing need for precautions. Residents were	
Findings include: assessed for elopement risk with	
care plan updates as needed.	
Resident X was identified by LPN (Licensed Residents identified as a risk for	
Practical Nurse) #1, during the orientation tour elopement have had their pictures	
3/11/2011 at 9:45 a.m., as having exit seeking placed in the facility watch book	
and wandering behaviors. In addition, she	
reported he had eloped twice. One witnessed and both nursing stations as well as	
the other unwitnessed. He was observed at the the employee break room	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG		COMPLI	ETED
		155338	A. BUII			03/14/20)11
			B. WIN				
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
				1	COUNTY ROAD 525 EAST		
		RVICES - PRESTWICK			IN46123		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		oidly through the facility with a			identifying them as elopement		
	stern facial expression. He was observed in the 600 hall, the 800 hall and the front lobby.				risks. What measures will be	e	
					put in place or what systemic	:	
					changes will be made to		
	Resident X's clinica	l record was reviewed on			ensure that deficient practice	es	
	3/11/2011 at 3 p.m. It indicated he was admitted				do not occur? All deliveries		
	to this facility on 12	2/2/2009. His diagnoses			other than regular mail or small	all	
	included, but were r	not limited to, Parkinson's			packages are now made to the	e	
	disease, dementia,	depression and anxiety. It			rear service entrance, away fr	om	
	indicated Resident 2	X had exhibited exit seeking			all resident common areas.		
	behavior and wande	ering consistently since			Coded entry locks have been		
	admission and that l	he periodically expressed			added to the entrances leadin	٠ ،	
	delusions that his wife was leaving him and he				the service hall. A new came		
	needed to be home. He also experienced dreams				was installed in the front lobby	'	
	of a similar nature which he found difficult to				with a corresponding monitor		
	separate from reality	y. At these times, his anxiety			installed for viewing from the		
		ecame agitated and intensely			North nurses' station. Magnet		
		as wearing a WanderGuard			locks, keypads and Wander G	ard	
		onically locks the doors when			Systems were installed at the		
	the device comes cl				exits from the North and South		
					dining rooms. Staff have been		
	The nursing notes in	ndicated on Saturday,			re-educated regarding exit		
		at X stayed in the front lounge			seeking behavior and unsafe		
		When a visitor exited the main			wandering. This education ha		
		Resident X "bolted" from a			been added to the general fac		
		where he'd been sitting and			orientation agenda and new s		
	_	le it was still open, pushing			will receive the education before	"E	
		is way to the outside. The			completion of their orientation		
	_	who then found the resident in			How will the corrective		
		condominiums, equivalent to a			actions(s) be monitored to		
	1 ' '	door. He fell as he attempted			ensure the deficient practice		
		d was brought back inside. A			will nor recur? The facility wi		
		ned interview of LPN #2 on			continue with missing resident drills once per shift per month		
		Resident X was" upset about			with the Safety Chair person of		
	his wife."	apoet acout			designee reviewing results with		
					the monthly QA & A. Daily aud		
	In response to the 2	/19/2011 elopement, the			of door/alarm functionality by		
		staff monitoring of Resident			Maintenance director or desig		
		him on a leave of absence from			and reviewed by the monthly		
		ppeared calm upon his return,			& A committee. Wander guar		
	and identity and ite a	ppeared cann apon ms return,			wander guar	~	

0TZ011

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			EY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED)
		155338	B. WIN			03/14/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			1	COUNTY ROAD 525 EAST		
MANIODO		NUCES DESTAUCK		1			
WANORO	JAKE HEALIH SER	RVICES - PRESTWICK		AVON,	IN46123		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	E CO	MPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
		g was discontinued. The			bracelet are checked every sh		
	facility checked all WanderGuard doors and				with functionality checked daily		
		w stops and inserviced staff on			Unit Manages will complete da	· 1	
		rocedures. However, the fact			audit 5X weekly for 4 weeks a	nd	
		demonstrated he could plan an			any areas of concern will be		
		it out was not addressed.			addressed immediately and the as directed by the QA & A	C11	
		plan indicated there was an			committee. The Social Service	_	
		pement risk initiated on s not updated after the			Director/Designee completes a	I	
		at. The interventions remained			weekly audit of the facility water		
	as:	i. The interventions remained			books located at the reception		
		I placement and function q			desk, both nursing stations as		
	(every) shift " (initi	• •			well as the employee break ro		
		name) signs resident out and			to assure they remain current		
	·	when leaving and escort back			reviews this with the monthly (QA	
	into the building" (i	_			& A committee.		
		ation with others and provide					
	_	nming, woodworking, read					
	magazine" (initiated	-					
	Nursing notes on Mo	onday, 3/7/2011 indicated					
	facility staff became	aware Resident X was					
	_	noon. He had last been seen at					
	* *	a.m. A "code green" was					
		ne Administrator indicated					
	_	1/2011 at 10:50 a.m., was the					
		r announcing to staff a resident					
		ch time staff systematically					
		g and grounds. When					
		located, the Administrator					
		dicated that while talking with					
	_	told him the police had located rs-by had spotted the resident					
		e intersection of U.S. highway					
	, ,	d 400 and notified the police.					
		ndicated he'd sent the					
		visor to check on the resident,					
	*	ad the resident in the					
		him the resident was being					
	sent to the emergence						
	<u> </u>	-					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUIL DDIG		COMP	LETED
		155338	A. BUILDING		— 03/14/2	2011
			B. WING	EET ADDRESS, CITY, STATE, ZIP	- CODE	
NAME OF P	PROVIDER OR SUPPLIER	2				
NANIODO		NUCEO PRECTANCIA	l l	S COUNTY ROAD 525 E	AST	
MANORO	JAKE HEALTH SER	RVICES - PRESTWICK	AVC	N, IN46123		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		n obtained from the "History				
	for KIND, Indiana" website 3/13/11 at 9 p.m.					
		11 in the Indianapolis area,				
		2:30 p.m. was 35.6 degrees				
		ind speed of 9.2 miles per				
		the temperature was 39.9				
	_	speed of 9.2 miles per hour.				
		ndicated during interview a.m., Resident X was dressed				
		shirt with another shirt pulled				
	_	-				
	over that, slacks and moccasins. He was not wearing a jacket, coat, sweater, etc.					
	wearing a jacket, co	at, sweater, etc.				
	Review of the emers	gency room documentation for				
		e on 3/11/2011 at 1:30 p.m. It				
		nt was received in the				
	emergency room at	14:40 (2:40 p.m.) on 3/7/2011,				
	which was 2.5 hours	s after the resident was noted				
	missing from the fac	cility. He had fallen in a ditch				
	along highway 36. I	He was discharged from the				
		18:42 (6:42 p.m.) with				
	-	pain and injury, contusions,				
	_	sions, neck injuries and				
	urinary tract infection	on."				
		indicated Resident X was again				
		oring which was still in effect				
		pement risk care plan had				
		2011. The new interventions				
		e in Center Watch Book and on w to vent feelings and/or				
		eeded) and assist with calling				
	* `	er to assist with calming."				
	wire, kids, or orothe	i to assist with cullilling.				
	There was no evider	nce a psychological evaluation				
		Resident X since this				
	elopement.					
	The Administrator n	nade an entry in the Social				
		-				

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING				COMPLETED		
155338		B. WI	B. WING				03/14/2011			
NAME OF D	DOMDED OD CLIDDLIED		-	STREET ADDRESS, CITY, STATE, ZIP CODE						
NAME OF P	ROVIDER OR SUPPLIER			445 S COUNTY ROAD 525 EAST						
MANORO	CARE HEALTH SER	RVICES - PRESTWICK		AVON, IN46123						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN O	F CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		E	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG				DATE		
	Service progress notes dated 3/11/2011. In this									
	entry he documented a conversation with Resident									
	X's family and indicated other placement was									
	being sought for Resident X for his safety.									
	"Explained we strongly recommend a secured									
	unit for himFamily wants to consider other									
	options. Explained that we would like to move (Resident's name) asap (as soon as possible) but									
		sap (as soon as possible) but ossible. Family expressed								
		basis w (with) (resident's								
		that his desire to elope is								
		table and that he should be								
		Il timesFamily agreed to								
	review all discharge	e options and cooperate."								
	During interview 3/	11/2011 at 10:50 a.m., the								
		ated they had not been able to								
		dent X eloped on 3/7/11. He								
		ad been interviewed and								
	Resident X wasn't te	elling.								
	An immediate jeopa	ardy was identified on								
	3/11/2011 at 4:45 p.1	m. The immediate jeopardy								
	began on 2/19/2011	when Resident X first eloped								
		he Administrator and the								
	•	were notified of the immediate								
		ack of supervision to prevent								
	an elopement on 3/1	11/2011 at 4:45 p.m. The								
	immediate jeopardy	y was removed on								
	3/7/2011 when reco	ords and interviews								
	conffrmed that the	resident was on								
	contnuous 1:1 mon	nitoring since return to								
	the ffacility The ffac	cility' s noncompliance								
		el off no actual harm with								
		e than minimal harm that								
	is not immediate jed									
		fully implement its plan to								
	•	upply deliveries more								
	make the site hol st	uppry deliveries more								
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	0TZ011	Facility I	D: 000231 I	If continuation sh	ieet Par	ge 14 of 15		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155338	B. WING		03/14/2011			
NAME OF I	PROVIDER OR SUPPLIER			FADDRESS, CITY, STATE, ZIP CODE COUNTY ROAD 525 EAST				
		RVICES - PRESTWICK	AVON, IN46123					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
	Center Watch Book, cameras on the mai inservice all staff.	key pad lock; to update its to install surveillance in entrance area; and to ites to complaint IN00087451.						